Medication Authorization Form

School Year ______________

Student: ____ DOB: _______________ Grade __________

PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE

DIAGNOSIS/SIGNIFICANT FINDINGS:

HISTORY:

ALLERGIES:

MEDICATIONS REQUIRED DURING SCHOOL HOURS *All authorizations expire at the end of the school year or following Extended Year Summer session (Sp.Ed)*					
Medical Condition	Medication	Strength	Time	Route	Possible Side Effects
1.					
2.					
3.					
4.					

*****Medication is to be supplied in the original/prescription container.*****

TREATMENTS/PROCEDURES REQUIRED DURING SCHOOL HOURS

(i.e., peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)

Medical Condition	Treatment/Procedure	Time(s)/Frequency	Special Instruction
1.			
2.			
3.			

Inhaler:

☐ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epi-pen:

☐ Student may carry/self administer his/her Epi-Pen/auto-injector according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

Other:

☐ Student may carry/self administer _________________ (Please identify).

________________________________ ________________________________ ___________________

Print Name of Physician/Licensed Prescriber — Physician's/Licensed Prescriber's Signature — Date

________________________________ ____________________________ ___________________

Clinic Address — Clinic Phone # — Clinic Fax #

Please fax this form to my student's school nurse. Fax number:_______________________________

(Parent/Guardian Authorization on Reverse Side)

Updated: November 2020

Parent/Guardian Medication Authorization

Student: __________________________ Grade: ______
Allergies: _____________________________________
(if not provided by licensed prescriber)

1. I request that the medication(s) and/or treatment(s)/procedure(s) ordered be given / performed during school hours as ordered by this student's physician/licensed prescriber.
2. I will provide the school with physician/licensed prescriber authorization **for any change** in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
3. I give permission for the school nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
4. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designated personnel as delegated by the school nurse.
5. I understand that school health personnel cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from my student's physician/licensed prescriber.
6. Only daily medications and those for life threatening/emergency conditions will be sent on field trips. The administration of medications and delegation may be different when on field trips.
7. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).

___________ ____ _____________________________
Date Parent/Guardian Signature Relationship to Student

Note: We request all controlled substances be brought in/picked up by parent/guardian. Please call the Health Office to form an alternative plan if this is not possible.

Self-Administration of Medication Student Agreement

I, ______________________________ agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school (form, assignment notebook)
- Not allow anyone else to use my medication.
- Keep a current supply of my medication located: __________________________.
- I will make sure I have my medication available for field trips or other off-site school events.
- Notify the school nurse or health support of any of the following circumstances:
  _____My symptoms continue or get worse after taking my medication
  _____I suspect that I have side effects from my medication
  _____I need my medication more frequently than ordered (i.e., inhaler more than every 4 hours).

____ **Locker # __________ Room # _________**
Signature of Student Date

The student has demonstrated knowledge about and proper use of his/her medication:

____
Signature of Health Office Staff Date

Updated: November 2020